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ROLES OF HEALTHCARE PROVIDERS IN MANAGEMENT OF ANXIETY DISORDER IN PRIMARY CARE

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Abstract:
Anxiety disorders are common mental health issues that are primarily treated in primary care settings. We did a narrative analysis of potential strategies for managing healthcare in countries with universal primary healthcare. Additionally, we examined the impact of treatment providers on the effectiveness of psychiatric treatment. In April 2022, a systematic search was conducted on databases such as PubMed, Cochrane, PsycINFO, CINAHL, and Scopus. The purpose was to identify controlled studies that focused on evidence-based anxiety treatment in primary care. Only studies published in English since 1995 were included in the search. Psychological interventions for anxiety are efficacious in primary care settings and exhibit more efficacy when administered by a specialist (such as a psychologist or clinical psychologist) as opposed to a non-specialist (such as a general practitioner, nurse, or trainee). Nevertheless, individuals without specialized expertise are capable of delivering efficacious treatment in comparison to receiving no care whatsoever. Prescribers must carefully assess the little information on the effectiveness of pharmacological treatments in primary care.

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INTRODUCTION:

Anxiety disorders represent the most prevalent group of mental diseases [1].Anxiety disorders have a detrimental impact on one's lifestyle and are also linked to significant healthcare and productivity expenses [2].Adults suffering from an anxiety condition typically seek treatment in primary care settings.However, the quality of care for people with anxiety disorders is suboptimal in many places and requires improvement[1].Despite medical guidelines recommending cognitive behavioral therapy (CBT) or antidepressant medication as the preferred therapies in healthcare, these evidence-based interventions are seldom implemented effectively in primary care settings [3].

The World Health Organisation conducted a comprehensive study on mental health care, which revealed a prevalence rate of 10.1% for anxiety disorders[1].Anxiety disorders are common disorders that occur in the general population with a 12-month frequency ranging from 2.4% to 18.2% [2].The prevalence rates for different subcategories of anxiety disorders are as follows: 0.6-5.2% for social phobia (SP), 0.5-3.8% for generalized anxiety disorder (GAD), and 0.3-4.0% for obsessive compulsive disorder (OCD) [3],[4].

As a result, general practitioners often encounter these issues in their patients. The most common types include panic disorder, with or without agoraphobia, as well as generalized anxiety disorder [2]. Anxiety disorders are commonly managed by general practitioners by the administration of antidepressants or benzodiazepines. These medications exhibit efficacy, but they also have some disadvantages, such as the potential for reliance, adverse effects, and insufficient patient adherence. Furthermore, symptoms of anxiety often reappear when the medications are discontinued [5]. These drawbacks are superfluous in therapy methods grounded in cognitive and behavioral principles. Nevertheless, primary care settings are typically unsuitable for implementing such programs due to their time-consuming nature and the requirement for extensive expert training. The majority of studies investigating the effectiveness of cognitive behavioural therapy (CBT) have been conducted in secondary treatment settings [5].

Considering the significant coexistence and prevalence of depression and anxiety disorders, it is reasonable to investigate treatments in order to enhance the standard of care for these conditions. The objective of this research is to identify the existing management strategies to enhance the medical diagnosis and treatment of persons with anxiety disorders, with or without a concurrent depressive condition, by General practitioners.

DISCUSSION:

- **DIAGNOSTIC CHALLENGES**

Family physicians often fail to accurately diagnose anxiety problems. A study conducted on 840 primary care clients found that the rates of misdiagnosis were 85.8% for panic disorder (PD), 71% for generalized anxiety disorder (GAD), and 97.8% for social anxiety disorder (SAD) [6].The initial stage in achieving an accurate medical diagnosis is to comprehend the problem. Table 1 provides a concise overview of the key characteristics of the primary anxiety disorders. Regrettably, client explanations of their symptoms sometimes mislead even the most astute medical experts. Clients may express physical or emotional discomfort, such as bodily complaints, unease, sleep disturbances, and melancholy, without realizing that they are actually feeling anxiety [7].According to Wittchen and colleagues, only 13.3% of individuals with Generalized Anxiety Disorder (GAD) presented with anxiety symptoms as their main concern, while somatic concerns were reported 47.8% of the time [8].Conducting a screening for prominent indicators and symptoms linked to the illness can assist in identifying the diagnosis. Individuals with anxiety disorders sometimes exhibit comorbidity with other mental illnesses, further complicating the diagnosing process.

Table 1. Anxiety Disorders [7].

Anxiety Disorders
Panic disorder (PD)
Specifier: with or without agoraphobia
Panic disorder with agoraphobia (AG, PDA)
Social phobia (SP)
Specifier: generalized
Specific phobias (SPP)
Specifier: animal, environmental, blood-injection injury, situational type
Post-traumatic stress disorder (PTSD)
Specifier: acute versus chronic, with delayed onset
Acute stress disorder
Obsessive–compulsive disorder (OCD)
Specifier: with poor insight
Anxiety disorders due to:
Specifier: with generalized anxiety, with panic attacks, with obsessive–compulsive symptoms

Most persons (70%-90%) with anxiety or depression present to their primary care provider with a somatic complaint [9].While some individuals may experience a specific physiological symptom such as diarrhea or sleeplessness, others may present with a variety of seemingly unrelated symptoms [10].Patients with anxiety commonly have physical symptoms such as migraines, digestive issues, muscle discomfort, breast soreness or rigidity, and palpitations. The presence of signs and symptoms that cannot be medically accounted for following a first examination may heighten the clinician's uncertainty regarding the presence of an anxiety or depressive disease [9].Approximately 40% to 50% of patients experiencing signs and symptoms that cannot be explained clinically are found to have an anxiety disorder, regardless of the precise sign(s) [11].While the specific type of the physical difficulties may not correspond, there is evidence to suggest that a wider range of somatic signs and symptoms is associated with a greater likelihood of an underlying psychiatric condition [11].

During the evaluation of a psychological health issue, the healthcare provider must carefully explore possible medical causes for the individual's complaints. Given the circumstances, it is imperative that the clinician maintains a compassionate and supportive attitude towards the patient. Every patient, especially those who are concerned, yearn to be listened to and have their concerns acknowledged with sincerity. By establishing such a relationship, the healthcare professional cultivates a sense of trust and positivity with the patient, which will eventually serve as the foundation for accepting the diagnosis, whether it pertains to a psychological or physical health issue, or both, and the subsequent prescribed treatment plan. Providing premature comfort can be detrimental when dealing with nervous persons who may feel misunderstood and disrespected if not treated in a considerate and systematic manner. Some individuals may require a comprehensive evaluation before the diagnosis of anxiety may be confirmed. The primary clinical causes of anxiety that are frequently cited are typically related to the endocrine or neurologic systems [9]. It may be necessary to conduct routine laboratory tests, such as a metabolic panel, thyroid function tests, or cortisol levels, to rule out electrolyte problems, hyperthyroidism, or Cushing's syndrome, particularly. A thorough investigation of the individual's medical and social history should include inquiries on the utilization of drugs, illicit substances, vitamins, or herbs. An assessment should be conducted on those who consume significant amounts of caffeine, alcohol, and nicotine [10].

Symptoms of specific anxiety disorders.

The diagnosis of certain anxiety disorders involves identifying the particular focus of the anxiety. For instance, if a person experiences panic attacks and also tends to catastrophize them as indicative of an impending heart attack or asphyxia, a medical diagnosis of panic attack may be necessary. However, if anxiety or panic attacks occur exclusively in response to direct exposure to social situations, then the diagnosis may be social phobia (Figure 1). The Diagnostic and Statistical Manual of Mental Disorders (fourth edition, text revision) (DSM-IV-TR) provides comprehensive diagnostic criteria [12].Indeed, within the standard practice framework, many individuals do not cleanly conform to this structure and exhibit symptoms of multiple disorders without matching the criteria for a specific disease.

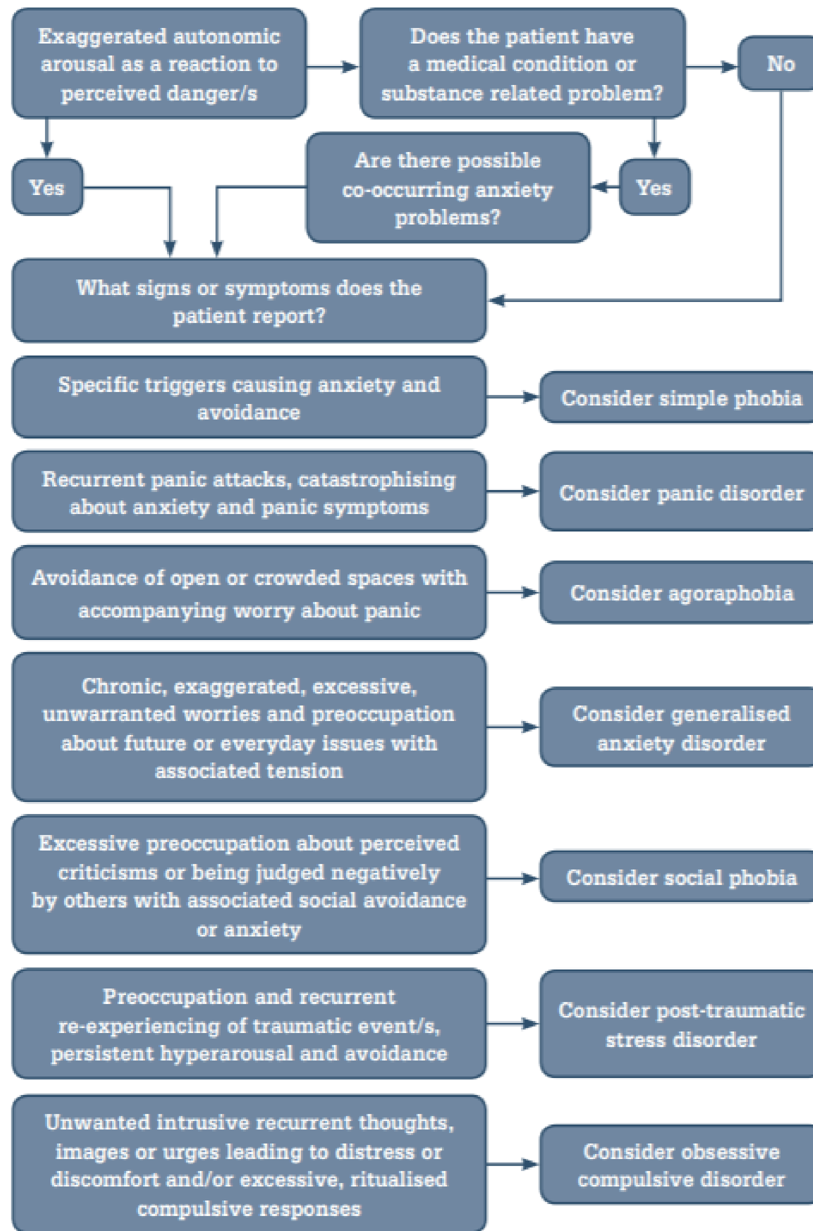

Figure 1. Differential diagnosis of anxiety disorders [12].

Screening tools

An array of efficient screening techniques are available for the detection of anxiety disorders (Table 2). Allocating time to utilize these accessories can prove to be difficult in a busy primary care practice. Tools designed to address the entire range of concurrent affective and anxiety disorders are particularly effective. The Hospital Anxiety and Depression Scale assesses the coexistence of clinical depression and anxiety [12].Additional comprehensive instruments, such the PRIME-MD-PHQ, have the capability to detect anxiety and mood disorders.

The Generalized Anxiety Disorder-7 (GAD-7) is a widely used and validated assessment tool for Generalized Anxiety Disorder (GAD), as well as for panic disorder and posttraumatic stress disorder (PTSD) [13].Recently, a shorter version called the GAD-2 has been discovered to have an 86% sensitivity and 83% specificity in identifying GAD when a rating of 3 or above is recorded [14].

Various PTSD assessment measures have been utilized in both military and civilian healthcare settings. An expedient assessment tool among these

tests is the 4-item Primary Care PTSD Screen. There are four yes/no questions that are related to possible symptoms of PTSD that have occurred during the previous month: nightmares/intrusive thoughts, avoidance of certain thoughts/situations, being overly alert/easily startled, and feeling emotionally numb/detached [15].Freedy and his colleagues conducted a study utilizing a sample of civilian primary care patients. They determined that the sensitivity was 85.1% and the specificity was 82.0% based on a threshold rating of 3. They utilized the Clinician-Administered PTSD Scale as the gold standard for comparison [16].Similar levels of sensitivity and specificity have been found for military cases [15].While routine screening for anxiety disorders is not universally recommended, it can still be advantageous, particularly when there are support systems in place to care for individuals who test positive. Primary care providers that establish strong collaborative partnerships with mental health experts in the community can assist these patients in effectively navigating the healthcare system towards a more comprehensive treatment plan for their mental well-being.

Table 2. Screening tools [13-16].

Diagnosis	Screening Tools	Screening Question
GAD	GAD-7 GAD-2	Do you consider yourself a worrier?
SAD	SPIN Mini-SPIN	When you are in a situation where people can observe you, do you feel nervous and worry that they will judge you?
PD	PHQ panic disorder scale	Do you have waves of nervousness that come out of the blue and you notice things in your body like your heart goes fast or it is hard to breathe?
PTSD	PC-PTSD PCL-C M-3	Have you experienced a trauma that still haunts you?
OCD	MINI Y-BOC PRIME-MD	Do you have thoughts that occur over and over that really bother you? Are there things you have to do over and over, such as washing your hands, checking, or counting?

First-Line Therapies. Several medicines are easily accessible for the treatment of anxiety (see table 3). SSRIs are typically the initial treatment of choice for generalized anxiety disorder (GAD) and panic disorder (PD) [17],[18].Tricyclic antidepressants (TCAs) have been extensively studied for their efficacy in treating panic disorder (PD), but they are also considered to be useful for both generalized anxiety disorder (GAD) and PD [17],[18].TCAs are equally effective as SSRIs in the treatment of PD, however adverse effects may restrict the use of TCAs in certain patients. Venlafaxine, an extended-release medication, is both efficacious and well-tolerated for Generalized Anxiety Disorder (GAD) and Panic Disorder (PD). On the other hand, duloxetine (Cymbalta) has only been thoroughly evaluated for GAD. Azapirones, such as buspirone (Buspar), demonstrate superior efficacy compared to placebo in treating generalized anxiety disorder (GAD), although their effectiveness in treating panic disorder (PD) appears to be inconsistent [20].There is conflicting evidence indicating that bupropion (Wellbutrin) may cause anxiety in certain people. Therefore, it is important to closely monitor individuals who use bupropion for treating depression, seasonal affective disorder, or quitting smoking.Bupropion is not approved for the treatment of Generalized Anxiety Disorder (GAD) or Panic Disorder (PD).

Table 3. The pharmacotherapy of anxiety disorders. according to the German guidelines [20].

Disease type	Active substance class	Drug	Daily dose
Social phobia			
	SSRI	Escitalopram	10–20 mg
		Paroxetine	20–50 mg
		Sertraline	50–150 mg
	SNRI	Venlafaxine	75–225 mg
	MAO inhibitors	Moclobemide	300–600 mg
Panic disorder			
	SSRI	Citalopram	20–40 mg
		Escitalopram	10–20 mg
		Paroxetine	20–50 mg
		Sertraline	50–150 mg
	SNRI	Venlafaxine	75–225 mg
	TCA	Clomipramine	75–250 mg
Generalized anxiety disorder			
	SSRI	Escitalopram	10–20 mg
		Paroxetine	20–50 mg
	SNRI	Venlafaxine	75–225 mg
		Duloxetine	60–120 mg
	Anticonvulsants	Pregabalin	150–600 mg
	Anxiolytic drugs (tricyclic)	Opipramol	50–300 mg
	Azapirones	Buspirone	15–60 mg

It is advisable to gradually adjust the dosage of drugs in order to reduce the first stimulation. Due to the frequent hold-up in start of activity, medications need to not be regarded inefficient up until they are titrated to the high end of the dose array as well as proceeded for at the very least four weeks. Once symptoms have improved, medications should be used for a year before gradually reducing the dosage to prevent a return [26].Certain customers may require extended treatment.

Benzodiazepines have been found to be useful in reducing anxiety. However, it is important to note that there is a relationship between the dosage of benzodiazepines and the occurrence of tolerance, drowsiness, confusion, and increased mortality[21].When used with antidepressants, benzodiazepines may expedite the alleviation of anxiety-related symptoms but do not enhance long-term outcomes. The increased risk of addiction and adverse effects complicates the usage of benzodiazepines [22].The NICE criteria suggest that it is advisable to use it only for a limited period of time in specific circumstances [26].Benzodiazepines that have an intermediate to long duration of action, such as clonazepam (Klonopin), are associated with a lower potential for misuse and a reduced risk of rebound effects [23].

Second-Line Therapies. Pregabalin (Lyrica) and quetiapine (Seroquel) are considered as second-line treatments for Generalized Anxiety Disorder (GAD). However, it is important to note that neither of these medications has undergone a specific review for Panic Disorder (PD). Pregabalin demonstrates more efficacy than placebo but is less effective than lorazepam (Ativan) for Generalized Anxiety Disorder (GAD). Pregabalin commonly leads to weight gain as a negative consequence. The data supporting the use of antipsychotics for treating anxiety disorders is scarce.

Quetiapine has shown effectiveness in treating generalized anxiety disorder (GAD), however it is important to note that it might cause significant adverse effects such as weight gain, diabetes mellitus, and hyperlipidemia [24].Hydroxyzine is considered a secondary therapy option for generalized anxiety disorder (GAD), however there is limited research on its effectiveness in panic disorder (PD) [25].The rapid onset of this medication can be highly effective for patients requiring immediate relief, and it may be a preferable option when benzodiazepines are not recommended (e.g., in those with a history of substance misuse). Psychiatrists may occasionally recommend gabapentin (Neurontin) as an alternative treatment for anxiety when benzodiazepines are not recommended, based on medical experience. It is worth mentioning that the placebo response for drugs used to treat Generalized Anxiety Disorder (GAD) and Panic Disorder (PD) is significant.

The treatment of anxiety problems is widely recognized as being less than ideal due to a lack of Cognitive Behavioral Therapy (CBT) experts or affordable therapy sessions. There is a significant need to extract the fundamental qualities of excellent care and incorporate them into the healthcare system, emphasizing education and training for the workforce. Oxford University Press has released numerous exemplary manuals comprising both expert and patient guides [27].Further research is needed to examine the efficacy of Internet-based, self-administered treatments and their ability to reach a wider audience [28].While specific phobias can often be effectively self-treated, complex anxiety disorders typically require professional intervention and may not be adequately addressed through self-treatment alone. In certain cases, the support of a trusted friend or family member can be beneficial in managing a specific fear.

Koszycki et al. examined the efficacy of self-administered cognitive-behavioral therapy (CBT) as a standalone treatment or in combination with therapist-directed CBT, self-administered CBT, or medication augmented with self-administered CBT [29]. Their research indicated that self-administered therapy could be a valuable addition to the range of cognitive-behavioral therapy techniques.

While numerous therapies demonstrate efficacy in treating anxiety, it is important to note that not all individuals will benefit from every therapy, and certain therapies may not be useful for all types of anxiety disorders. Managing an uncomplicated phobia is less challenging compared to a complex case of post-traumatic stress disorder (PTSD). SSRIs and CBT are two therapies that have strong empirical backing. The relapse rates for cognitive-behavioral therapy (CBT) in comparison to medication have not been extensively investigated. However, based on our professional experience, CBT has a more enduring treatment effect provided the individual continues to apply the skills and tools acquired during therapy.

CONCLUSION:

Psychiatric diseases, particularly anxiety disorders, are common in primary care settings. However, despite being as common as depression, they often receive less attention and remain unrecognized and untreated. The significant prevalence of concurrent psychiatric disorders and physical ailments leads to varied and potentially misleading manifestations. Patients typically do not typically associate their health issues with psychological disorders. They actively oppose these medical diagnoses and demonstrate a strong reluctance to accept treatment. On a daily basis, these factors, combined with limited time for client encounters, hinder general practitioners' accurate diagnosis of anxiety disorders. General practitioners has the ability to effectively recognize and manage individuals with various anxiety disorders. Many people would undoubtedly benefit from the utilization of psychotherapy and/or psychopharmacology. Complex or severe anxiety disorders are most effectively managed by thorough evaluation and collaborative efforts with psychiatrists and psychologists that specialize in this field.

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